Combined Financial Services Guide and Product Disclosure Statement

Important information about
nib Expatriate Health Insurance

Effective 15 August 2016

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Financial Services Guide

This Financial Services Guide (FSG) explains the financial services that you will receive from **us** when you obtain a quotation and when purchasing a **policy** through **us**.

This FSG is designed to help you decide whether the financial services **we** provide are suitable for you.

We provide it in combination with the Product Disclosure Statement (PDS), which contains information about the features, benefits, terms and conditions of this insurance policy.

About us

This insurance is underwritten by certain underwriters at Lloyd's (Insurer).

Cerberus Special Risks Pty Limited, ABN 81 115 932 173, AFSL 308461 (Cerberus) is an Australian Financial Services Licensee authorised to provide financial product advice and deal in general insurance products.

Cerberus is the underwriting agent acting for the Insurer and holds a binding authority from the Insurer, which authorises Cerberus to issue, vary, renew or cancel your insurance. This means that Cerberus acts as the Insurer's agent and not as your agent.

Cerberus has appointed nib Global Pty Ltd ABN 77 102 599 619, AR 1244248 (nib), as its authorised representative to assist in the management of its insurance activities, provide general advice and arrange to issue this nib Expatriate Health Insurance **policy**. nib acts on behalf of Cerberus and not on your behalf.

nib will also assist with claims management but claims will be handled and settled by **AXA** PPP International (a trading name of **AXA** PPP Healthcare Limited) (**AXA**). **AXA** is appointed by the Insurer and is authorised to handle and settle claims on behalf of the Insurer.

Our contact details

nib Global Pty Ltd

ABN 77 102 599 619
Authorised Representative No. 1244248
1800 941 012
+61 2 4047 0965 (when outside Australia)
nibexpathealth@nib.com.au
22 Honeysuckle Drive
Newcastle NSW 2300
Australia
Mon-Fri: 8am – 8.30pm (AEST)

Cerberus Special Risks Pty Limited

ABN 81 115 932 173
AFS Licence No. 308461
1300 625 229
PO Box A975
Sydney South NSW 1235
Australia

AXA PPP International

+44 (0) 1892 556014
Phillips House
Crescent Road
Tunbridge Wells
Kent TN1 2PL
United Kingdom

Remuneration

In providing financial services, Cerberus receives a percentage of the gross **premium** from the Insurer when you buy a **policy**. Cerberus pays a percentage of its commission to nib for its role in arranging to issue the **policy**. If the Insurer makes an underwriting profit in a given year, Cerberus may receive a profit commission based on the performance and profitability of all insurances placed by Cerberus.

Representatives of Cerberus and nib receive an annual salary. They may also receive a bonus subject to them satisfying certain performance criteria, including sales. nib may also work with brokers and other Affiliates (‘Affiliate’) who introduce or refer customers to nib. If you are referred to nib by an Affiliate, the Affiliate who referred you may be paid a referral fee or commission from the commission that nib receives from Cerberus. The referral fee or commission is calculated as a percentage of the gross **premium** when you buy a **policy** and is at no extra cost to you. Depending on certain eligibility criteria, an Affiliate may receive additional benefits such as discounted travel insurance or marketing assistance from nib.

If you would like more information about the remuneration that nib or Cerberus receives, please contact nib.

Professional indemnity insurance

Cerberus and its representatives (including nib) are covered under professional indemnity insurance arrangements that comply with the requirements of Chapter 7 of the Corporations Act. The insurance (subject to its terms and conditions) will continue to cover claims in relation to Cerberus’ representatives that no longer works for it (but who did at the time of the relevant conduct).

How we handle complaints

If you are unhappy with the financial services provided by the Insurer, Cerberus or nib please contact nib's Customer Relations team during office hours at:

1800 941 012
+61 2 4047 0965 (when outside Australia)
nibexpatcomplaints@nib.com.au
22 Honeysuckle Drive
Newcastle NSW 2300
Australia
Mon-Fri: 8am – 8.30pm (AEST)

nib will respond to your complaint within 15 business days. If more time is needed to collect necessary information or complete any further investigation required, nib will agree with you a reasonable alternative timeframe.

If you are not satisfied with the response by nib in relation to your complaint, you should contact certain underwriters at Lloyd's for consideration under their internal dispute resolution process. You can contact Lloyd's at:

+61 2 8298 0783
idraustralia@lloyds.com
Lloyd's Underwriters General Representative in Australia
Level 9
1 O'Connell Street
Sydney NSW Australia 2000

The length of time required to resolve a complaint by Lloyd's will depend on the individual issues, however, you will normally receive a response within 15 business days of receipt, provided Lloyd's has received all necessary information and has completed any investigation required.

If you are not satisfied with the outcome of your complaint by **our** internal dispute resolution scheme, or if your complaint has not been resolved to your satisfaction within 45 days of making your complaint, you can choose to have your complaint independently reviewed by the Financial Ombudsman Service (FOS).

FOS is an independent external dispute resolution scheme approved by the Australian Securities and Investments Commission (ASIC). The General Insurance Division of FOS offers a free and accessible dispute resolution service to consumers.

You can contact FOS during office hours at:

Phone: 1300 780 808 or +61 3 9613 7366
Email: info@fos.org.au
Fax: +61 3 9613 6399
Financial Ombudsman Service Limited
GPO Box 3
Melbourne VIC 3001
www.fos.org.au

Responsibility for this document

Cerberus is responsible for the Financial Services Guide, and the Insurer is responsible for the Product Disclosure Statement. Distribution of this FSG is authorised by Cerberus.

Date prepared: 2 August 2016

Date effective: 15 August 2016

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Product Disclosure Statement

Before you buy

When purchasing this insurance **policy**, **we** ask that you become familiar with the information outlined in this document to ensure the insurance cover offered is right for your circumstances.

This document is made up of:

- the Financial Services Guide (FSG) (which the **policyholder** should read first and which begins on page 5) is designed to help the **policyholder** make an informed decision about the financial services **we** provide and outlines how **we** are remunerated and how **we** will deal with complaints and disputes; and
- the Product Disclosure Statement (PDS) (which begins on page 9) and states what is covered and what is not covered, sets out the claims procedure, exclusions and other terms and conditions of cover and it is designed to help the **policyholder** decide if this insurance **policy** is right for the **policyholder** and/or the **insured persons**.

Who can buy?

The **policyholder** is a party to this contract of insurance and an **insured person** is not a party to this contract of insurance and does not enter into any agreement with **us**. The **insured person** is not a contracting insured under the **policy** with **us** unless the **insured person** is also the **policyholder** stated in the **certificate of insurance**.

An **insured person** is not obliged to accept any of the benefits of this insurance. However, if an **insured person** makes a claim under the **policy** then the **insured person** will have the same obligations to **us** as if they were the **policyholder** and **we** will have the same rights against the **insured person** as **we** otherwise would have against the **policyholder**.

The cover under this insurance **policy** is only available to persons who satisfy the age limits and underwriting criteria of the plan selected. This insurance **policy** is designed for permanent residents and citizens of Australia, their **spouse** or **partner** and **dependent child(ren)** that intend to reside outside of Australia for a stated period of time.

When am I covered?

This **policy** should be purchased at least 30 days prior to requiring cover in the **country of assignment**. Cover for all benefits under each Section applicable to the **policy** begins on the date an **insured person** arrives in the **country of assignment** and ends on the date of return to the **country of residence** as stated in the **certificate of insurance**.

Where applicable, and at **our** absolute discretion, an **insured person** may be eligible for up to 14 days of cover after an **insured person** is no longer an **employee** at the request of the **policyholder** and provided the 14 days of cover does not extend beyond the end of the **period of insurance**.

The **policy** is only valid once the **premium** is paid and **we** issue a **certificate of insurance**. Only persons stated in the **certificate of insurance** are covered by the **policy**.

Please make sure the **certificate of insurance** and this document are kept safe together with any other documents **we** send, as these contain all the information about the **policy**.

Summary of benefits and cover

The following is a summary of benefits and levels of cover available under the **policy**. You should read each **policy** section for a full description of the coverage, terms, conditions and exclusions that apply. You should also read the General conditions and General exclusions which are applicable to all sections of this **policy**.

Section 1 – Hospital in-patient benefits provides cover for **hospital treatment**, **in-patient psychiatric treatment**, **companion accommodation**, **ambulance transport**, **prosthetic implants and internal appliances**, **prosthetic limbs**, **kidney dialysis**, radiotherapy and chemotherapy, **hospice and palliative care**, **in-patient diagnostic tests and pathology**, HIV/AIDS and **day-care treatment**.

Section 2 – International Emergency Medical Assistance provides cover for **International Emergency Medical Assistance**, **repatriation of mortal remains** and **close relative travel and accommodation**.

Section 3 – Medical out-patient benefits provides cover for **doctors and specialists expenses**, **out-patient prescribed medicines and dressings**, **out-patient psychiatry and psychology**, **physiotherapy and chiropractic**, **alternative treatment**, **home nursing** and **out-patient diagnostic tests and pathology**.

Section 4 – Additional benefits provides cover for **preventative health screening**, **vaccinations**, **preventative and general dental**, **major restorative dental**, **orthodontic dental**, **accident related dental**, **routine optical** and **medical aids and equipment**.

Section 5 – Maternity benefits provides cover for **in-patient routine delivery**, **out-patient pre and post-natal expenses**, **home delivery**, pre and post-natal **complications and delivery complications** and newborn child **congenital defect**.

The range of benefits and levels of cover available will depend on the plan you choose.

We offer a choice between a Top Plan, a Mid Plan, and a Basic Plan to individuals and organisations.

We also offer a Corporate Plan to organisations requiring cover for multiple **employees**. The benefits and benefit limits in the Corporate Plan may be varied or the Corporate Plan itself may be tailored for individual organisations. Cover under the Corporate Plan is only available to organisations that satisfy **our** underwriting criteria and approved by **us** in writing.

The plan and level of cover provided to you will be stated in the **certificate of insurance** and are subject to the terms, limitations, conditions, and exclusions of the **policy**. Certain terms used in this summary are defined in the **policy**, either under General definitions or as definitions applicable to specified sections. Please refer to the General definitions as well as the relevant sections for these definitions.

Plans

The summary tables below help you identify the **policy** benefits and levels of cover for each plan. The benefit limits applies to each **insured person** for each **period of insurance** unless otherwise stated in the **certificate of insurance** which may be subject to an **excess**, **waiting period** or **co-payment** as stated in the **certificate of insurance**.

Top Plan

Annual aggregate limit per **insured person**	Up to a maximum of $2,500,000
Deductibles/excesses	Applicable to sections 1, 3, 4 and 5 $0, $250, $500, $1,000, $1,500, $2,000
Area of cover	1. Worldwide or 2. Worldwide excluding USA
Benefit category/section	**Section 1: Hospital in-patient benefits**
Hospital treatment	Paid in full up to annual aggregate limit per **insured person**
In-patient psychiatric treatment	Up to a maximum of $15,000
Companion accommodation	Up to a maximum of $150 per night
Ambulance transport	Paid in full up to annual aggregate limit per **insured person**
Prosthetic implants and internal appliances	Paid in full up to annual aggregate limit per **insured person**
Prosthetic limbs	Up to a maximum of $5,000
Kidney dialysis	Paid in full up to annual aggregate limit per **insured person**
Radiotherapy and/or chemotherapy	Paid in full up to annual aggregate limit per **insured person**
Hospice and palliative care	Up to a maximum of $40,000
In-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Day-care treatment	Paid in full up to annual aggregate limit per **insured person**
HIV/AIDS	Up to a maximum of $100,000

Benefit category/section	Section 2: International Emergency Medical Assistance
International Emergency Medical Assistance	Paid in full up to annual aggregate limit per **insured person**
Repatriation of mortal remains	Paid in full up to annual aggregate limit per **insured person**
Close relative travel and accommodation	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 3: Medical out-patient benefits**
Doctors and specialists	Paid in full up to annual aggregate limit per **insured person**
Out-patient prescribed medicines and dressings	Up to a maximum of $1,500
Out-patient psychiatric and psychology	Up to a maximum of $2,500
Physiotherapy and chiropractic	85% of the actual cost up to a maximum of $2,000
Alternative treatment	85% of the actual cost up to a maximum of $1,000
Home nursing	Up to a maximum of $3,000
Out-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 4: Additional benefits**
Preventative health screening	Up to a maximum of $1,000
Vaccinations	Up to a maximum of $1,000
Preventive and general dental	Up to a maximum of $750
Major restorative dental	75% of the actual cost up to a maximum of $1,500
Orthodontic dental	75% of the actual cost up to a maximum of $1,500
Accident related dental	Paid in full up to annual aggregate limit per **insured person**
Routine optical	Up to a maximum of $500
Medical aids and equipment	Up to a maximum of $500
Benefit category/section	**Section 5: Maternity benefits**
In-patient routine delivery	Up to a maximum of $15,000 12 months **waiting period** (if applicable)
Out-patient pre and post-natal expenses	Up to a maximum of $10,000 12 months **waiting period** (if applicable)
Home delivery	Up to a maximum of $2,500 12 months **waiting period** (if applicable)
Pre and post-natal complications and delivery complications	Paid in full up to annual aggregate limit per **insured person** 12 months **waiting period** (if applicable)
Newborn child congenital defects	Up to a maximum of $100,000 12 months **waiting period** (if applicable)

Mid Plan

Annual aggregate limit per **insured person**	Up to a maximum of $2,000,000
Deductibles/excesses	Applicable to sections 1, 3 and 4 $0, $250, $500, $1,000, $1,500, $2,000
Area of cover	1. Worldwide or 2. Worldwide excluding USA
Benefit category/section	**Section 1: Hospital in-patient benefits**
Hospital treatment	Paid in full up to annual aggregate limit per **insured person**
In-patient psychiatric treatment	Up to a maximum of $10,000
Companion accommodation	Up to a maximum of $150 per night
Ambulance transport	Paid in full up to annual aggregate limit per **insured person**
Prosthetic implants and internal appliances	Paid in full up to annual aggregate limit per **insured person**
Prosthetic limbs	Up to a maximum of $5,000
Kidney dialysis	Paid in full up to annual aggregate limit per **insured person**
Radiotherapy and/or chemotherapy	Paid in full up to annual aggregate limit per **insured person**
Hospice and palliative care	Up to a maximum of $30,000
In-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Day-care treatment	Paid in full up to annual aggregate limit per **insured person**
HIV/AIDS	Up to a maximum of $100,000
Benefit category/section	**Section 2: International Emergency Medical Assistance**
International Emergency Medical Assistance	Paid in full up to annual aggregate limit per **insured person**
Repatriation of mortal remains	Paid in full up to annual aggregate limit per **insured person**
Close relative travel and accommodation	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 3: Medical out-patient benefits**
Doctors and specialists	Paid in full up to annual aggregate limit per **insured person**
Out-patient prescribed medicines and dressings	Up to a maximum of $1,000
Out-patient psychiatric and psychology	Up to a maximum of $2,500
Physiotherapy and chiropractic	85% of the actual cost up to a maximum of $1,500

Alternative treatment	85% of the actual cost up to a maximum of $500
Home nursing	Up to a maximum of $3,000
Out-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 4: Additional benefits**
Preventative health screening	Up to a maximum of $500
Vaccinations	Up to a maximum of $500
Preventive and general dental	Up to a maximum of $750
Major restorative dental	50% of the actual cost up to a maximum of $1,500
Orthodontic dental	50% of the actual cost up to a maximum of $1,500
Accident related dental	Paid in full up to annual aggregate limit per **insured person**
Routine optical	Up to a maximum of $300
Medical aids and equipment	Up to a maximum of $500

Basic Plan

Annual aggregate limit per **insured person**	Up to a maximum of $1,500,000
Deductibles/excesses	Applicable to sections 1 and 3 $0, $250, $500, $1,000, $1,500, $2,000
Area of cover	1. Worldwide or 2. Worldwide excluding USA
Benefit category/section	**Section 1: Hospital in-patient benefits**
Hospital treatment	Paid in full up to annual aggregate limit per **insured person**
In-patient psychiatric treatment	Up to a maximum of $5,000
Companion accommodation	Up to a maximum of $150 per night
Ambulance transport	Paid in full up to annual aggregate limit per **insured person**
Prosthetic implants and internal appliances	Paid in full up to annual aggregate limit per **insured person**
Prosthetic limbs	Up to a maximum of $5,000
Kidney dialysis	Paid in full up to annual aggregate limit per **insured person**
Radiotherapy and/or chemotherapy	Paid in full up to annual aggregate limit per **insured person**
Hospice and palliative care	Up to a maximum of $20,000
In-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Day-care treatment	Paid in full up to annual aggregate limit per **insured person**
HIV/AIDS	Up to a maximum of $100,000

Benefit category/section	Section 2: International Emergency Medical Assistance
International Emergency Medical Assistance	Paid in full up to annual aggregate limit per **insured person**
Repatriation of mortal remains	Paid in full up to annual aggregate limit per **insured person**
Close relative travel and accommodation	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 3: Medical out-patient benefits**
Doctors and specialists	Paid in full up to annual aggregate limit per **insured person**
Out-patient prescribed medicines and dressings	Up to a maximum of $500
Out-patient psychiatric and psychology	Up to a maximum of $2,500
Physiotherapy and chiropractic	85% of the actual cost up to a maximum of $1,000
Alternative treatment	85% of the actual cost up to a maximum of $500
Home nursing	Up to a maximum of $3,000
Out-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**

Corporate Plan

Annual aggregate limit per **insured person**	Up to a maximum of $3,000,000
Deductibles/excesses	Applicable to sections 1, 3, 4 and 5 $0, $250, $500, $1,000, $1,500, $2,000
Area of cover	1. Worldwide or 2. Worldwide excluding USA
Benefit category/section	**Section 1: Hospital in-patient benefits**
Hospital treatment	Paid in full up to annual aggregate limit per **insured person**
In-patient psychiatric treatment	Up to a maximum of $20,000
Companion accommodation	Up to a maximum of $250 per night
Ambulance transport	Paid in full up to annual aggregate limit per **insured person**
Prosthetic implants and internal appliances	Paid in full up to annual aggregate limit per **insured person**
Prosthetic limbs	Up to a maximum of $5,000
Kidney dialysis	Paid in full up to annual aggregate limit per **insured person**
Radiotherapy and/or chemotherapy	Paid in full up to annual aggregate limit per **insured person**

Hospice and palliative care	Up to a maximum of $50,000
In-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Day-care treatment	Paid in full up to annual aggregate limit per **insured person**
HIV/AIDS	Up to a maximum of $100,000
Benefit category/section	**Section 2: International Emergency Medical Assistance**
International Emergency Medical Assistance	Paid in full up to annual aggregate limit per **insured person**
Repatriation of mortal remains	Paid in full up to annual aggregate limit per **insured person**
Close relative travel and accommodation	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 3: Medical out-patient benefits**
Doctors and specialists	Paid in full up to annual aggregate limit per **insured person**
Out-patient prescribed medicines and dressings	Up to a maximum of $2,000
Out-patient psychiatric and psychology	Up to a maximum of $2,500
Physiotherapy and chiropractic	85% of the actual cost up to a maximum of $3,000
Alternative treatment	85% of the actual cost up to a maximum of $1,500
Home nursing	Up to a maximum of $3,000
Out-patient diagnostic tests and pathology	Paid in full up to annual aggregate limit per **insured person**
Benefit category/section	**Section 4: Additional benefits**
Preventative health screening	Up to a maximum of $1,500
Vaccinations	Up to a maximum of $1,500
Preventive and general dental	Up to a maximum of $1,000
Major restorative dental	85% of the actual cost up to a maximum of $2,000
Orthodontic dental	85% of the actual cost up to a maximum of $2,000
Accident related dental	Paid in full up to annual aggregate limit per **insured person**
Routine optical	Up to a maximum of $1,000
Medical aids and equipment	Up to a maximum of $500
Benefit category/section	**Section 5: Maternity benefits**
In-patient routine delivery	Up to a maximum of $20,000 12 months **waiting period** (if applicable)

Out-patient pre and post-natal expenses	Up to a maximum of $15,000 12 months **waiting period** (if applicable)
Home delivery	Up to a maximum of $5,000 12 months **waiting period** (if applicable)
Pre and post-natal complications and delivery complications	Paid in full up to annual aggregate limit per **insured person** 12 months **waiting period** (if applicable)
Newborn child congenital defects	Up to a maximum of $100,000 12 months **waiting period** (if applicable)

Important matters

Applying for cover

When applying for cover, **we** will confirm details such as the **period of insurance**, **premium**, what cover options and **excesses** will apply and, where applicable, any changes to the **policy** or level of cover which will be given in writing to the **policyholder**. These details are stated in the **certificate of insurance** and any other documentation **we** issue to the **policyholder**.

If you have any queries, want further information about this document, or want to confirm a transaction, please contact your insurance broker, your nib business development manager or the nib contact centre.

About your premium

The **policyholder** will be advised of the **premium** payable for the **policy** when offered the insurance. It is based on a number of factors such as the **area of cover**, the **country of assignment**, number of people covered, and the **insured persons** age, **pre-existing conditions**, plan type and past claims experience where appropriate.

The **premium** also includes amounts that take into account **our** obligation to pay any compulsory government charges, taxes or levies (e.g. Stamp Duty and GST) in relation to the **policy** where applicable. These amounts will be set out separately in the **certificate of insurance** and appear as part of the total **premium**.

Changes to the policy

Please check all the **policy** documents and make sure all the information is correct as these documents reflect the cover provided to the **policyholder** and **we** rely on this information when dealing with the **policy**. If there are any errors, please contact your insurance broker, your nib business development manager or the nib contact centre.

Where circumstances change resulting in a change in the cover under the **policy**, please contact your insurance broker, your nib business development manager or the nib contact centre so **we** can make the changes. In some circumstances **we** can change the cover or issue a new **policy**. A new **certificate of insurance** will be issued to the **policyholder** if any change in the level of cover is made.

Cooling off period

The **policyholder** has up to twenty one (21) days from the time the **certificate of insurance** is issued to change your mind and cancel the cover with no obligation. This is called the cooling-off period.

If the **policyholder** decides that the **policy** is not required, the **policyholder** may cancel it within the cooling-off period. The **policyholder** will receive a full refund of the **premium** paid less taxes and charges which **we** are unable to recover, provided:

(a) an **insured person** has not arrived in the **country of assignment**;

(b) an **insured person** hasn't made a claim; and

(c) a **policyholder** and/or an **insured person** do not intend to make a claim or exercise any other right under the **policy**.

The **policyholder** can cancel the **policy** during the cooling off period by contacting nib.

The duty of disclosure

Before you enter into, vary or extend an insurance contract, you have a duty of disclosure under the Insurance Contracts Act 1984.

When **we** ask you questions that are relevant to **our** decision to insure you and on what terms, you must tell **us** anything that you know and that a reasonable person in the circumstances would include in answering the questions. When amending or extending your contract of insurance, **we** will ask you specific questions about any change in your circumstances. You must tell **us** about any change to something you have previously told **us** otherwise you will be taken to have told **us** that there is no change. You have this duty until **we** agree to insure, amend or extend the contract.

If you do not tell us something

If you do not tell **us** anything you are required to tell **us**, **we** may cancel your contract or reduce the amount **we** will pay you if you make a claim, or both.

If your failure to tell **us** is fraudulent, **we** may refuse to pay a claim and treat the contract as if it never existed.

Non-payment of premium

The **policyholder** must pay the **premium** or any additional **premium** that **we** request on time, otherwise the **policy** may not operate. **We** have the right to cancel the **policy** for non-payment of **premium**.

If a claim is made under the **policy** while any **premium** is outstanding, and provided that **we** have not informed the **policyholder** that the **policy** is or will be cancelled, **we** may pay a claim subject to a condition that the **policyholder** pays the payment of the **premium**, or **we** may deduct any outstanding **premium** from the claim payment.

General Insurance Code of Practice

The Insurance Council of Australia Limited has developed the General Insurance Code of Practice (the Code), which is a self-regulatory code for adoption by insurers. **We** proudly support the Code and embrace its objectives of raising the standards of practice and service in the insurance industry. A copy of the Code can be obtained from the following website www.codeofpractice.com.au

Utmost good faith

We, the **policyholder** and/or any **insured person** will act towards each other in good faith. Failure to do so by the **policyholder** and/or the **insured person** may prejudice the entitlement to claim under the **policy**.

Policy excesses

If the **policyholder** and/or the **insured person** make a claim under the **policy**, the **policyholder** and/or the **insured person** may be required to pay an **excess**. This is the amount that is first contributed towards each claim under the **policy**.

For example, if an **insured person** has cover provided under Section 1: Hospital in-patient benefits and makes a claim for **in-patient psychiatric treatment** in the nett eligible amount of one thousand dollars ($1,000) and an **excess** of two hundred and fifty dollars ($250) applies, then the **policyholder** or the **insured person** will be asked to pay two hundred and fifty dollars ($250) towards the loss and **we** will pay seven hundred and fifty dollars ($750) upon acceptance of the eligible portion of the claim.

Jurisdiction and choice of law

This **policy** is governed by and construed in accordance with the law of New South Wales, Australia, and the **policyholder** and or the **insured person** agree to submit to the exclusive jurisdiction of the courts of New South Wales. Equally **we**, in accepting this insurance, agree that:

(a) If a dispute arises under this **policy**, this **policy** will be subject to Australian law and practice and **we** will submit to the jurisdiction of any competent court in the Commonwealth of Australia;

(b) Any summons notice or process to be served upon the underwriters may be served upon Lloyd's Underwriters' General Representative in Australia, Level 9, 1 O'Connell Street, Sydney NSW 2000 who has authority to accept service and to appear on the underwriters' behalf; and

(c) If a suit is instituted against **us**, **we** will abide by the final decision of such court or any competent appellate court.

Updating this Product Disclosure Statement

This PDS is current for the **period of insurance** stated in the **certificate of insurance**. From time to time, **we** may need to update this PDS or issue a Supplementary PDS (SPDS) if certain changes occur, where required and permitted by law. If the changes are material and affect the **policy**, **we** may issue the **policyholder** with a new PDS and/or SPDS to update the relevant information.

We ask that the **policyholder** reads the new PDS and/or SPDS in full to understand the changes, as they may affect the level of cover or the decision to purchase cover with **us**.

Our contract with the policyholder

The **policy** is a contract of insurance between **us** and the **policyholder** and contains all the details of the cover that are provided.

Access by an **insured person** to this **policy** is solely by reason of the statutory operation of section 48 of the Insurance Contracts Act 1984 (Cth). The **policyholder** is a party to this contract of insurance and an **insured person** is not a party to this contract of insurance and does not enter into any agreement with **us**. An **insured person** cannot cancel or vary this **policy**.

We do not need to provide any notices in relation to this **policy** to an **insured person** as the **insured person** is not a contracting party to the **policy**. **We** will only send notices to the **policyholder** as it is the only entity to which **we** have contractual obligations under this **policy**.

The **policy** is made up of:

1. this PDS;
2. the **application** form (where relevant), which is the information you provide to **us** when applying for insurance cover;
3. the most current **certificate of insurance** issued by **us**. The **certificate of insurance** is a separate document unique to the **policyholder** that shows the insurance details relevant to the **policyholder** and/or the **insured person**. It includes the level of cover, any changes, exclusions, terms and conditions made to suit the individual circumstances and any amendments to the **policy**; and
4. any other written changes advised by **us** in writing (such as an endorsement or a Supplementary PDS). These written changes vary or modify the above documents.

Please note, only those Sections stated as covered in the **certificate of insurance** are covered under the **policy**.

This document is also the PDS for any offer of renewal **we** may make, unless **we** advise otherwise. Please keep the **policy** in a safe place.

We reserve the right to change the terms of this **policy** where permitted to do so by law. In these circumstances, **we** will advise the **policyholder** of any of these changes as soon as practicable.

General advice

Any general advice that may be contained in this document does not take into account the individual objectives, financial situation or specific needs of **insured persons**, the **policyholder** or other persons stated in the **certificate of insurance** nor those for whom the **policyholder** is effecting the **policy**. Such matters should be considered in determining the appropriateness of this **policy**. Consideration also needs to be given to whether the limits, type and level of cover are appropriate.

Any person who may be eligible for cover under this insurance **policy** should consider obtaining advice as to whether the benefits are appropriate or useful for their personal needs from a person who is licensed to give such advice. No advice is provided by **us** that the benefits are appropriate or useful for any **insured persons** own circumstances or needs and which might otherwise be covered under separate insurance taken out by them.

Privacy notice

When you are applying for or renewing a **policy** with **us** or when **we** are processing a claim or otherwise dealing with you or an **insured person**, in order to help **us** properly administer a proposal, **policy** or claim, **we** and **our** service providers including nib, Cerberus, **AXA** and others who provide financial services to you will collect personal information (including in some circumstances sensitive information) about **insured persons** from you and those **insured persons** directly, from those authorised by you and **insured persons** such as family members, expatriated companions, **doctors**, **specialists** and **hospitals**, dentists, chiropractors, physiotherapists and other ancillary medical service providers, and from others **we** consider

necessary including **our** business partners, government agencies, service providers and also publicly available sources.

If you or an **insured person** do not give **us** this personal information, **we** may not be able to provide insurance or process a claim.

The personal information (including sensitive information) **we** collect about **insured persons** is used to provide financial services and other services, such as emergency medical assistance, and to manage your and **our** rights and obligations (and those of **insured persons**) in relation to providing financial services, including managing, processing and investigating claims and recovery against third parties. **We** may also use and disclose such personal information for product development, marketing, competitions, research, IT systems maintenance and development, and for any other purposes with your consent, or where required or authorised by Australian law.

The personal information (including sensitive information) of **insured persons** may be disclosed to third parties involved in the above process, such as **our** service providers, **doctors**, **specialists** and **hospitals**, dentists, chiropractors, physiotherapists and other ancillary medical service providers, insurers and reinsurers, claims handlers, investigators and cost containment providers, legal and other professional advisers, law enforcement, regulatory and government agencies and courts where **we** are required or authorised by Australian law, your and **our** agents (and those of **insured persons**), and also **our** related companies.

Some of these third parties may be located in other countries, such as the UK and USA. Certain underwriters at Lloyds and **AXA** are located in the UK. There may be certain circumstances that require disclosure of your personal and sensitive information to these third parties in these other countries in order for **us** to be able to provide services and assistance in connection with the cover under the **policy** to you and for the benefit of **insured persons**. Please note that no personal information is disclosed by **us** to any third party overseas entity for marketing purposes.

Where **we** collect personal information (including sensitive information) about **insured persons** from you, **we** rely on you having made each **insured person** aware of the matters set out in this Privacy Notice, and require you to confirm that you have the consent of each **insured person** to provide their personal information (including sensitive information) to **us**.

The Privacy Policy of Cerberus is available at www.cerberusspecialrisks.com.au and the Privacy Policy of nib at www.nib.com.au/legal/privacy-policy. These Privacy Policies each include further information about how Cerberus and nib (respectively) collect, use, disclose and handle personal information, and how you and **insured persons** may seek access to their personal information and have it corrected, and make a complaint or raise any other concerns about their compliance with the Privacy Act 1988 (Cth) including the Australian Privacy Principles (APPs) and any registered APP codes that bind them.

What's covered and what's not

Section 1: Hospital in-patient benefits

Cover

We will cover the **insured person** for the actual, **medically necessary** and reasonable expenses, resulting from a **bodily injury** and/or **sickness** that are incurred outside of an **insured person's country of residence**, within the **area of cover** and during the **period of insurance** for Hospital in-patient benefits as stated in this document and up to the benefit limits as stated in the **certificate of insurance** for any one (1) **period of insurance**.

Benefits

- Hospital treatment
- In-patient psychiatric treatment
- Companion accommodation
- Ambulance transport
- Prosthetic implants and internal appliances
- Prosthetic limbs
- Kidney dialysis
- Radiotherapy and/or chemotherapy
- Hospice and palliative care
- In-patient diagnostic tests and pathology
- Day-care treatment
- HIV/AIDS treatment

Specific definitions applying to Section 1

ambulance transport means local road ambulance that is **medically necessary** emergency transport to or between **hospitals**.

companion accommodation means accommodation for a **close relative** to stay in the same **hospital** room as the **insured person** or at a hotel/motel near the **hospital**.

daily accommodation means a standard single room whilst an **insured person** is admitted as an in-patient or a day-patient.

day-care treatment means a treatment as an in-patient within a **hospital** or day-patient in a day care unit (where a discharge summary is issued by the **hospital**) and require a supervised recovery that does not necessitate an **insured person** to occupy a **hospital** bed overnight. This excludes all forms of **alternative treatment**.

hospice and palliative care means care whilst admitted to a specialist palliative care or hospice centre recognised by **us**, following diagnosis by, and written confirmation (including medical evidence) from a **doctor** and/or **specialist** that an **insured person** is suffering from a terminal **sickness** and its associated **sicknesses**.

hospital treatment means all **in-patient treatment** which is provided to an **insured person** by a **doctor** and/or **specialist** in a **hospital** between admission and discharge including:

i. **In-patient diagnostic tests and pathology**
ii. Surgical procedures
iii. Operating theatre costs

iv. Nursing care, drugs and dressings

v. Surgical appliances used by the **doctor** or **specialist** during surgery except external prosthesis or orthosis or appliances.

vi. Surgeon and anaesthetist costs

vii. Intensive care unit costs

viii. Consultations and physiotherapy

ix. **Radiotherapy and/or chemotherapy**

x. Special nursing in **hospital**

xi. Organ transplant

xii. **Daily accommodation**

xiii. Reconstructive surgery

xiv. Prescribed medicines

HIV/AIDS treatment means treatment which is provided to an **insured person** for the Human Immunodeficiency Virus (HIV) or any variation or develops Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC).

in-patient diagnostic tests and pathology means computerised tomography, magnetic resonance imaging, x-rays, ultrasounds, positron emission tomography and gait scans, examinations of samples including but not limited to blood and tissue undertaken in a **hospital**.

in-patient psychiatric treatment means **in-patient treatment** by a registered psychiatrist.

in-patient treatment means treatment in a **hospital** where an **insured person** has to stay in a **hospital** bed overnight excluding all forms of **alternative treatment**.

kidney dialysis means the artificial process of eliminating waste (diffusion) and unwanted water (ultrafiltration) from the blood which is required in the event the **insured persons** kidneys have been damaged by a **bodily injury** and/or **sickness** which will not carry out the function properly.

prosthetic limbs means an artificial replacement for a missing body part such as an arm, hand, leg or total joint replacement and includes a device designed and applied to improve function.

prosthetic implant and internal appliances means artificial substitutes for body parts (excluding limbs and dental implants) and materials inserted into tissue for functional purposes. Prostheses prescribed must be functional purposes.

radiotherapy and/or chemotherapy means ionizing radiation and/or cytotoxic substances to control or kill malignant cells.

Specific conditions applying to Section 1

Cover for Hospital in-patient benefits under the **policy** is subject to the following specific terms, conditions and exclusions:

1. in relation to the **daily accommodation**, if an **insured person** chooses to stay in a room at the **insured persons** discretion that **we** do not consider to incur reasonable costs relating to a standard single room (i.e. upgrading the room), the **insured person** will be liable to pay any differences as an out of pocket cost. This also extends to include any difference in costs associated with the treatment provided in such instances where these increase as a result.
2. in relation to the costs associated with **prosthetic limbs**, **we** will pay for fitting, maintenance, consultations and surgical procedures.

3. in relation to **ambulance transport**, the **doctor** and/or **specialist** treating an **insured person** will determine if it is **medically necessary**. **We** however reserve the right to ultimately determine whether such transportation was deemed to be **medically necessary** and to subsequently decide whether such benefit will be paid under the **policy**.
4. in relation to organ transplants, **we** will pay for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of a **bodily injury** or **sickness** and provided these organs have been sourced from a relative or certified and verified source of donation.
5. The **insured person** must maintain the current level of cover (or lower) stated in the **certificate of insurance** at the commencement of the **policy** for Hospital in-patient benefits throughout any hospice and palliative admission. This means that if the period of **hospice and palliative care** extends into a new **period of insurance** or a **policy** renewal, the **policyholder** must pay the **premium** for the subsequent **period of insurance** at the same or lower level of cover, or the benefit will cease at the expiry of the **period of insurance** applying under the **policy**.
6. In relation to reconstructive surgery, **we** will pay for the initial treatment plan subject to all of the following:
   i. it is **medically necessary**; and
   ii. it is carried out to restore function after an **accident**, **sickness** or following surgery, provided the **insured person** has been continuously covered under the **policy** prior to the **accident**, **sickness** or surgery occurring requiring the **insured person** to restore such function; and
   iii. it must be done at a medically appropriate stage after the **accident**, **sickness** or surgery.

Specific exclusions applying to Section 1

Subject to the other terms, conditions and exclusions of the **policy**, **we** will not cover or pay any benefits under Section 1 arising out of any:

1. elective treatment or services which are covered by Australian Medicare or a private health insurer, or by compensation under any Workers' Compensation legislation or scheme or Transport Accident laws or by any sponsored fund, government or medical benefit scheme of any country, or any other insurance policy required to be effected by or under a law of any country.
2. costs for **prosthetic limbs** unless they are following a surgery or from an **accident**.
3. costs of collecting donor organs (including but not limited to transportation and administration costs) or any expenses incurred by the donor.
4. **in-patient treatment** for medical conditions in respect of which treatment can be reasonably provided as an out-patient.

For the avoidance of doubt, the above exclusions extend to any tests, investigations, treatment, items, conditions, activities and any related consequential expenses connected with those exclusions.

Section 2: International Emergency Medical Assistance

Cover

We will cover the **insured person** for the actual, **medically necessary** and reasonable expenses that are incurred outside of an **insured persons country of residence**, within the **area of cover** and during the **period of insurance** for **International Emergency Medical Assistance** as stated in this document up to the benefit limits as stated in the **certificate of insurance** for any one (1) **period of insurance**.

24 hours, 7 days
1800 941 012 or +61 2 4047 0965 (if outside Australia)

Benefits

- International Emergency Medical Assistance
- Repatriation of mortal remains
- Close relative travel and accommodation

Specific definitions applying to Section 2

International Emergency Medical Assistance is provided by **AXA** Assistance, an international assistance company. This is a worldwide 365 days a year, 24 hours a day service for emergency evacuation and other related services as described within this **policy**.

international Emergency Medical Assistance means:

(a) costs for road ambulance that is **medically necessary** and emergency transport to or between **hospitals**. The **doctor** and/or **specialist** treating the **insured person** will determine if this is **medically necessary**.

(b) costs for economy airfares (where available) on a scheduled airline to transport the **insured person** to the nearest airport and to the recommended **hospital** where the **insured person** will receive specialised treatment, surgery or post-operative supervision. This includes ground transport required from the airport to the nearest **hospital** and return economy airfares (where available) to return the **insured person** to the **country of assignment** following evacuation.

(c) costs incurred to evacuate the **insured person** to the nearest **hospital** for specialised treatment or, surgery if a scheduled airline is not available and the **insured person** requires evacuation via the charter of an aircraft, air ambulance or any other available means of transport.

(d) costs for pre-hospitalisation and post hospitalisation accommodation:

  i. where certified by the attending **doctor** and/or **specialist**, the **hospital** and **our** assistance team as being **medically necessary** in preparation for **hospital** admission or following **hospital** discharge.

  ii. non recoverable costs incurred for hotel accommodation where the **insured person** is required by airline schedules to stay overnight en-route to **hospital**.

repatriation of mortal remains means the actual, necessary and reasonable costs as a result of:

(a) returning the **insured person's** mortal remains to the **country of residence**; or

(b) funeral and related expenses if the **insured person** is buried or cremated at the place of death.

close relative travel and accommodation means:

(a) costs incurred for a **close relative** to stay in the same **hospital** room as the **insured person** or at a hotel/motel near the **hospital** when the **insured person** is receiving **in-patient treatment** in the **hospital** and is **very seriously ill**.

(b) costs for economy airfares (where possible) for a **close relative** for the period of the **insured persons hospital in-patient treatment** including pre and post-hospitalisation periods if the **insured person** is medically evacuated and is **very seriously ill**.

(c) costs incurred by a **close relative** as a result of staying in the same **hospital** room or at a hotel/motel near the **hospital** when the **insured person** is receiving **in-patient treatment** in the **hospital**, under eighteen (18) years of age and medically evacuated.

(d) costs for economy airfares (where possible) for a **close relative** for the period of the **insured persons hospital in-patient treatment** including pre and post-hospitalisation periods if the **insured person** is under eighteen (18) years of age and medically evacuated.

Specific conditions applying to Section 2

The cover for **International Emergency Medical Assistance** under the **policy** is subject to the following specific terms, conditions and exclusions as follows:

1. evacuation must be **medically necessary** and must be undertaken at the nearest **hospital** where appropriate treatment can be given if it is unavailable in the **insured persons** location.
2. all cases must be assessed by **our** emergency assistance team, be deemed necessary for evacuation and/or repatriation, and all arrangements must be made by **our** assistance team in order to confirm that related costs are covered by the service and covered under the **policy**.
3. if arrangements are made by the **policyholder** and/or the **insured person**, those costs may not be covered under the **policy**.
4. any entitlement to **International Emergency Medical Assistance** does not mean that the **insured persons** treatment following evacuation or repatriation will be covered under the **policy**. Any such treatment will be subject to the terms and conditions of the **policy** and as stated in the **certificate of insurance**.
5. If the **insured person** is evacuated in an emergency, the **insured person** will subsequently be returned to the **country of assignment** once the **insured person** has been deemed fit to fly by the treating **doctor** and/or **specialist** and has been agreed to by **our** assistance team.
6. **International Emergency Medical Assistance** is not available in the event of:
   (a) any medical condition which is not a **bodily injury**, **sickness** or pregnancy, or which is excluded by operation of the general exclusions under the **policy**;
   (b) any **bodily injury**, **sickness** or pregnancy which does not need immediate **in-patient treatment** or which does not prevent an **insured person** from continuing to travel or to work.
7. The **policyholder** and/or the **insured person** must not attempt to resolve problems encountered without first informing **us** as this may prejudice reimbursement of expenses.

8. **we** reserve **our** rights against the **policyholder** and/or the **insured person** if the **policyholder** and/or the **insured person** do not make contact with **our** assistance team and/or any act or omission prejudices **our** rights under the **policy**. **We** have a discretion to consider cover if the **policyholder** and/or the **insured person** for reasons beyond the **policyholders** and/or the **insured persons** control, could not contact **our** assistance team and had no alternative but to make own arrangements, provided **we** are satisfied the arrangements which are made were necessary and reasonable having regard to the **insured persons bodily injury**, **sickness** or complication of pregnancy and/or that it was **medically necessary** at the time.
9. a benefit for **repatriation of mortal remains** will only be paid where death has occurred as a result of a **bodily injury**.

Specific exclusions applying to Section 2

Subject to the other terms, conditions and exclusions of the **policy**, **we** will not cover or pay any benefits under Section 2 arising out of any:

1. costs incurred after the **policyholder** and/or **insured person**, or any of the **policyholders** and/or **insured persons** representatives refuse to follow any instructions and directions issued by or through **our** assistance team.
2. costs associated with the **insured persons** requirement to be moved, repatriated, evacuated from a ship, oil-rig platform or similar off-shore location.
3. circumstances where **we** have not been informed of the **accident**, **bodily injury** or **sickness** in respect of which any emergency evacuation and other related services as described within this **policy** is arranged within thirty (30) days of its occurrence.
4. claims as a result of the **insured persons** travel to a country that the Department of Foreign Affairs and Trade (DFAT) and/or the Foreign Commonwealth Office (UK) state as a place which for any reason it advises against travel.
5. any expenses or costs incurred after the **insured person** has been advised by a **doctor** and/or **specialist** against travelling.

For the avoidance of doubt, the above exclusions extend to any tests, investigations, treatment, items, conditions, activities and any related consequential expenses connected with those exclusions.

Section 3: Medical out-patient benefits

Cover

We will cover the **insured person** for the actual, **medically necessary** and reasonable expenses, resulting from a **bodily injury** and/or **sickness** that are incurred outside of an **insured persons country of residence**, within the **area of cover** and during the **period of insurance** for Medical out-patient benefits as stated in this document and up to the benefit limits as stated in the **certificate of insurance** for any one (1) **period of insurance**.

Benefits

- Doctors and specialists expenses
- Out-patient prescribed medicines and dressings
- Out-patient psychiatry and psychology
- Physiotherapy and chiropractic

- Alternative treatment
- Home nursing
- Out-patient diagnostic tests and pathology

Specific definitions applying to Section 3

alternative treatment means treatments provided by a podiatrist, dietician, naturopath, acupuncturist, homeopath, osteopath, and/or traditional Chinese practitioner for the alleviation of a **bodily injury** or **sickness** who is qualified, licenced and registered with the relevant statutory board or council to provide treatment. It also means treatments for prescribed vitamins, supplements and traditional Chinese medicines for the alleviation of a **bodily injury** or **sickness**.

doctors and specialist expenses means consultations made by a **doctor** and/or **specialist** for the treatment of health.

home nursing means the treatment of **bodily injury** or **sickness**, provided the care is considered necessary and reasonable as evidenced by a written statement by a **doctor** or **specialist**, and the treatment is provided by a person registered as a nurse who is not:

1. the **policyholder**;
2. an **insured person** covered under the **policy**;
3. a **close relative**; or
4. an **employee** or director of the **policyholder**.

out-patient prescribed medicines and dressings means medicines that have been prescribed to an **insured person** by a **doctor** or **specialist** for the treatment of a **bodily injury** or a **sickness**.

out-patient psychiatry and psychology means service provided by a duly qualified psychologist or psychiatrist for the provision of mental health services provided that an **insured person** is referred for such treatment by the treating **doctor** and/or **specialist**.

out-patient diagnostic tests and pathology means computerised tomography, magnetic resonance imaging, X-rays, ultrasounds, positron emission tomography and gait scans, examinations of samples including but not limited to blood, urine and tissue.

physiotherapy and chiropractic means treatment provided by a duly qualified physiotherapist and chiropractor for the alleviation and treatment of a **bodily injury**. It does not mean or include **alternative treatment**.

Section 4: Additional benefits

Cover

We will cover the **insured person** for the actual, **medically necessary** and reasonable expenses resulting from a **bodily injury** and/or **sickness** that are incurred outside of an **insured persons country of residence**, within the **area of cover** and during the **period of insurance** for Additional benefits as stated in this document and up to the benefit limits as stated in the **certificate of insurance** for any one (1) **period of insurance**.

Benefits

- Preventative health screening
- Vaccinations
- Preventative and general dental
- Major restorative dental

- Orthodontic dental
- Accident related dental
- Routine optical
- Medical aids and equipment

Specific definitions applying to Section 4

accident related dental means services performed by a **dentist** for emergency dental treatment that is **medically necessary** to restore or replace sound natural teeth lost or damaged as a result of an **accident** to resolve acute, spontaneous and unexpected onset of pain.

dentist means a person with a primary degree in dentistry from a recognised dentistry school, who is licenced and registered with the relevant statutory dental board or council to provide dental treatment.

major restorative dental means services performed by a duly qualified oral surgeon, maxillofacial surgeon or **dentist** for root treatment, endodontic treatment, oral surgery, anaesthetic services, periodontal surgery, interceptive orthodontic services, installation of and repairs to crowns and bridges and new dentures.

medical aids and equipment means instruments or devices or durable medical equipment which are prescribed by a **doctor** and/or **specialist** to aid function or capacity; such as but not limited to compression stockings, hearing aids, speaking aids (electronic larynx) wheelchairs, crutches, corrective splint and orthopaedic supports.

orthodontic dental means services performed by a duly qualified orthodontist for the purpose of straightening teeth and alignment of jaws.

preventative and general dental means services performed by a duly qualified oral surgeon or **dentist** for examinations, scaling and cleaning dental filling and restorations, diagnostic services, x-rays, injections and extractions of teeth.

preventative health screening means services provided by a **doctor** and/or **specialist** for the purposes of investigating and assessing the state of health.

routine optical means eye examinations, corrective spectacles and/or corrective contact lenses as prescribed by an ophthalmologist or optometrist.

vaccinations means administering antigenic material to stimulate the immune system to develop adaptive immunity to a pathogen.

Specific conditions applying to Section 4

This cover for Additional benefits is subject to the following terms, conditions and exclusions of the **policy**;

1. in relation to **accident related dental**, **we** will pay for the initial treatment required immediately (within seven (7) days) following accidental damage to natural teeth when that treatment is given by a **dentist**, provided that an **insured person** has been continuously covered under the **policy** prior to the **accident** occurring relating to initial treatment only and does not include any follow up.

Specific exclusions applying to Section 4

Subject to the other terms, conditions and exclusions of the **policy**, **we** will not cover or pay any benefits under Section 4 arising out of any:

1. **accident related dental** arising from:
    i. **bodily injury** caused whilst eating or drinking irrespective of whether a foreign body was found to be present; or
    ii. **bodily injury** caused by normal wear and tear, or
    iii. **bodily injury** having occurred whilst appropriate mouth protection was not worn where recommended to do so; or
    iv. **bodily injury** caused by tooth brushing or any other oral hygiene procedure; or
    v. **bodily injury** that was not apparent within seven (7) days of the **accident** which caused the **bodily injury**.

For the avoidance of doubt, the above exclusions extend to any tests, investigations, treatment, items, conditions, activities and any related consequential expenses connected with those exclusions.

Section 5: Maternity benefits

Cover

We will cover the **insured person** for the actual, **medically necessary** and reasonable expenses incurred and resulting from the risk of pregnancy or childbirth that are incurred outside of an **insured persons country of residence**, within the **area of cover** and during the **period of insurance** for Maternity benefits as stated in this document and up to the benefit limits as stated in the **certificate of insurance** for any one (1) **period of insurance**.

Benefits

- In-patient routine delivery
- Out-patient pre and post-natal expenses
- Home delivery
- Pre and post-natal complications and delivery complications
- Newborn child congenital defect

Specific definitions applying to Section 5

assisted conception/assisted pregnancy means the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg close together, thereby increasing the chance of conception. This includes but is not limited to intra-uterine insemination (IUI), in-vitro fertilisation (IVF), intra-cytoplasmic sperm injections (ICSI) or the use of any form of treatment to include or increase ovulation. This also includes surrogate conceptions.

home delivery means services performed at the place of **insured persons** residence for routine delivery of a newborn child.

in-patient routine delivery means vaginal delivery, or elective/ non-**medically necessary** caesarean delivery of a child including pre and post-natal **complications and delivery complications** that arise as a result of elective/non-**medically necessary** caesarean delivery of a child.

newborn child congenital defect means a birth defect and anomaly of a new born child that is deleterious, which can be either physical, mental or biochemical whether or not it manifested, diagnosed or known about at birth.

out-patient pre and post-natal expenses means costs for treatment and services directly associated with **in-patient routine delivery** that does not necessitate an overnight stay within a **hospital**.

pre and post-natal complications and delivery complications means (in addition to any other benefit) emergency delivery and/or complicated delivery provided the expenses are certified by the treating **doctor** and/or **specialist** as a result of natural conception or by **assisted conception/assisted pregnancy** including any associated costs for treatment and services. It also means any costs associated with the care, support and maintenance of the newborn child in the event the mother remains in **hospital**.

Specific conditions applying to Section 5

This cover for Maternity benefits is subject to the other terms, conditions and exclusions of the **policy** and the following specific conditions:

1. Any complications arising from a **medically necessary** caesarean delivery, such delivery will be paid from the **pre and post-natal complications and delivery complications** benefit limit.
2. For birth and any complications arising from elective or non-**medically necessary** caesarean delivery, **we** will pay for the delivery costs up to the costs of a vaginal delivery in-line with the **in-patient routine delivery** benefit limit.
3. If **we** are not able to determine that a caesarean section is **medically necessary**, **we** will treat it as elective caesarean delivery and not **medically necessary**.
4. The **policyholder** must upgrade the level of cover to family within thirty (30) days of an **insured person** giving birth irrespective of whether the birth related costs are covered under the **policy**. Failure to do so may prejudice the **policyholder** and/or **insured persons** entitlement to claim under the **policy**
5. In relation to a home birth, an **insured person** must:
   i. have a midwife who is registered as required by applicable legislation in the **country of assignment** to care for the **insured person** in labour and birth.
   ii. be prepared to be transferred to **hospital** if the midwife, **doctor** or **specialist** considers it **medically necessary**.
   iii. check with the local **hospital** if they provide home birth as an option.
   iv. book into the local **hospital** as a backup option in case of **pre and post-natal complications and delivery complications**.
   v. ensure the midwife, **doctor** and/or **specialist** offers a physical examination and screening check for the newborn child after birth. E.g. hearing test, testing for cleft palate, testes for boys, or is able to refer to **specialist** screening services as required.
   vi. have the newborn child checked by a **doctor** and/or **specialist** in the first week after birth.
   vii. ensure the newborn child is offered vitamin K and other treatments as required after birth.
   viii. be sure the midwife or **doctor** offers tests for the newborn child after the birth or refers to a service that does undertake them.

Specific exclusions applying to Section 5

Subject to the other terms, conditions and exclusions of the **policy**, **we** will not cover or pay any benefits under Section 5 arising out of any:

1. treatment of any **bodily injury** and/or **sickness** which is due to and occurs during the pregnancy prior to the delivery or after the delivery if the pregnancy was a result of assisted conceptions/ assisted pregnancy.

For the avoidance of doubt, the above exclusions extend to any tests, investigations, treatment, items, conditions, activities and any related consequential expenses connected with those exclusions.

General conditions

Home leave

This **policy** is intended to cover Australians residing overseas for actual, **medically necessary** and reasonable expenses incurred and resulting from a **bodily injury** and/or **sickness** suffered by an **insured person** outside of the **country of residence**. It is not a complying health insurance product for the purposes of Australian private health insurance legislation.

This **policy** does extend cover to an **insured person** for medical expenses while in the **country of residence** for a period of up to sixty (60) days per **period of insurance** (which may accumulate over more than one (1) trip to the **country of residence** but which must never exceed sixty (60) days in a **period of insurance**) provided that:

- The **insured person** is on **home leave** or personal leave, or
- The **insured persons** employment temporarily brings them back to the **country of residence**, or
- The **insured persons** return to the **country of residence** is as a result of being evacuated or repatriated,

and the **insured person** is not covered (or entitled to be covered) by Medicare or are a customer of an Australian private health insurance policy during that sixty (60) day period.

To qualify for an entitlement to receive a benefit which is covered under this **policy** while an **insured person** is on **home leave**, the **insured person** must, at all times, be temporarily employed outside the **country of residence** during the **period of insurance**. If the **insured person** ceases being temporarily employed outside the **country of residence** during the **period of insurance**, this **policy** only provides benefits in respect of the **area of cover** which excludes the **country of residence**.

Waiting periods on transfer to another nib policy

If the **insured person** returns to the **country of residence** permanently for any reason, and eligible for Australian private health insurance policy, the **insured person** is entitled to join another nib health insurance policy immediately. **We** will recognise any **waiting periods** already served under the **policy** and **we** will waive **waiting periods** that apply for **pre-existing conditions** (provided the **insured person** has been covered under the **policy** for twelve (12) or more consecutive months).

Any **premium** paid in advance for the **policy** will be treated in accordance with the cancellation provisions as outlined under Cancellation within the General conditions in the **policy** if an **insured person** returns to the **country of residence** permanently.

Currency

All amounts stated in the **policy** are in Australian Dollars (AUD). If there are any expenses incurred in a foreign currency, the rate of currency exchange used to determine the amount payable in Australian Dollars (AUD) will be determined at the time of incurring the expense. **We** will not be liable for any bank charges, credit charges, or foreign exchange losses.

Subrogation

We may, at **our** discretion, undertake in name of the **policyholder** and/or **insured person** and on behalf of the **policyholder** and/or **insured person**, control and settlement of proceedings for **our** own benefit to recover compensation or secure indemnity from any party in respect of anything covered by this **policy**. This is known as subrogation. You are to assist and permit to be done all acts and things as required by **us** for the purpose of recovering compensation or securing indemnity upon **us** paying your claim under this **policy**, regardless of whether **we** have yet paid your claim and whether or not the amount **we** pay you is less than full compensation for your loss.

Recovery

We will apply any money **we** recover from someone else under a right of subrogation in the following order:

1. To **us**, **our** administration and legal costs arising from the recovery;
2. To **us**, an amount equal to the amount that **we** paid the **policyholder** and/or **insured person** under the **policy**
3. To the **policyholder** and/or **insured person**, the **policyholder** and/or **insured persons** uninsured loss, less any **excess**
4. To the **policyholder** and/or **insured persons excess**.

Once **we** pay your total loss, **we** will keep all money left over. If **we** have paid your total loss and you receive a payment from someone else for that loss or damage, you must pay **us** the amount of that payment up to the amount of the claim **we** paid you.

We will not be liable for a loss where the **policyholder** and/or **insured person** is a party to an agreement that excludes or limits **our** rights to recover damages from a third party in respect of that loss, whenever that agreement was made, whether before or after any loss, **sickness**, injury or damage occurs or has occurred.

Additions and deletions

The **policyholder** must declare to **us** any additional person, including any newborn child, who is requested to be covered under the **policy** during the **period of insurance** within thirty (30) days of requiring cover before any acceptance by **us** to cover that additional person.

Cover for any additional person notified to **us** after commencement of the **policy** will be subject to payment of a pro-rata **premium**, which can be paid on a quarterly or annual basis.

The **policyholder** must also declare to **us** any persons for whom the **policyholder** no longer requires cover under the **policy** within thirty (30) days from the **insured persons** cessation date.

Change in level of cover

We do not allow a **policyholder** to upgrade or downgrade the level of cover during the **period of insurance** however **we** have the absolute discretion to review a particular risk under this **policy** and any cover requirements on a case by case basis. **We** will however allow a **policyholder** to upgrade or downgrade the level of cover at each **policy** renewal when requested in writing by the **policyholder**. **We** reserve the right to refuse any request to upgrade or amend cover. **We** will not pay upgraded benefit levels for treatment of any medical condition which arose or should reasonably have been foreseen by the **policyholder** and/or the **insured person** to arise prior to any upgrade in the cover becoming effective. The **policyholder** and/or **insured person** is required to declare any medical condition to **us** when requesting an upgrade. Where a medical condition is, or becomes apparent and has not been properly or reasonably disclosed by the **policyholder** and/or the **insured person** in accordance with the conditions and terms of the **policy** and this PDS, a benefit which is payable for such a medical condition, if any, will be limited to the benefit limit applying to the level of cover that would have been applicable to such a medical condition prior to the upgrade. For any **sickness**, **bodily injury**, pregnancy or any other medical condition occurring, contracted or sustained at any time on or after the effective date of a downgrade in the level of cover, notwithstanding that such **sickness**, **bodily injury**, pregnancy or any other medical condition occurs, is contracted or sustained during the period of insurances, **our** liability will be restricted to the benefit limits applicable to the downgraded or lower level of cover.

Dependent child(ren)

Dependent children will not continue to be covered under the **policy** after the **policy** renewal date if and once they have attained

(a) 19 years and they living and residing with the **insured person**; or

(b) 25 years and they are a full time student at an accredited institute of higher learning in the **country of assignment**, and are primarily dependent on the **insured person** for maintenance and support.

Cancellation

The **policyholder** may cancel the **policy** at any time by notifying **us** in writing. The cancellation will take effect at 4.01pm Australian Eastern Standard Time on the date **we** receive written notice of cancellation from the **policyholder**.

We may cancel the **policy** for any of the reasons set out in Section 60 of the Insurance Contracts Act 1984 (Cth) if the **policyholder** and/or the **insured person** has:

(a) failed to comply with the duty of disclosure; or

(b) made a misrepresentation to **us** at the time the **policy** was entered into; or

(c) failed to comply with a relevant provision of this **policy**; or

(d) made a fraudulent claim under the **policy** or any other **policy**; or

(e) failed to notify **us** of matters as required by the **policy**.

We will cancel the **policy** by issuing a notice thirty (30) days in advance in writing in accordance with Section 59 of the Insurance Contracts Act 1984 (Cth).

If the **policy** is cancelled by either the **policyholder** or **us**, **we** will refund the **premium** for the **policy** less a pro-rata proportion of the **premium** to cover the period for which insurance applied. However **we** will not refund any **premium** if **we** have paid a claim or benefit under the **policy**. Cover will end on the earlier of:

(a) The date when the **policyholder** or an **insured person** no longer satisfy the criteria stated in the **certificate of insurance**;

(b) The end of the **period of insurance**; or

(c) When the **policy** is cancelled by the **policyholder** in accordance with the **policy** or by **us** pursuant to the Insurance Contracts Act 1984 (Cth).

Cover in respect to a **spouse** or **partner** and/or **dependent children** will end on the earlier of:

(a) The date of when the **policyholder** cancels the **policy** subject to its terms; or

(b) The date such **spouse or partner** and/or **dependent child** ceases to be the **insured persons spouse** or **partner** and/or **dependent child**; or

(c) The date a **spouse or partner** and/or **dependent child** dies.

The **policyholder** may not be eligible to receive a **premium** refund if the **policyholder** and/or **insured person** have made a claim or the **policyholder** and/or the **insured person** are, or become entitled to make a claim under the **policy** in which case **we** will determine the eligibility to receive a refund of any **premium** at **our** absolute discretion at the **policy** renewal date of the **period of insurance** or once the **policyholder** and/or the **insured person** are no longer covered under the **policy**.

Other insurance

The **policyholder** and/or the **insured person** must advise **us** as to any other insurance under which the **policyholder** and/or the **insured person** are entitled to a claim or have access to, that covers the same risk as under the **policy**. The **policy** will not provide compensation cover, other than for any gap in cover, if the **policyholder** and/or the **insured person** have any other insurance in force or are entitled to indemnity from any other source.

It is a condition of the **policy** and any claim made by the **policyholder** and/or the **insured person** must first recover from someone or some other source (other than under an insurance **policy**). If they do not pay the **policyholder** and/or the **insured person** the full amount of the claim and that part is covered by the **policy**, **we** will make up the difference between the amount received and the relevant benefit limit under the **policy**.

Notice of claim

The **policyholder**, the **insured person** and/or any other person entitled to claim under the **policy** must give **us** written notice of any circumstances, incident or occurrence which is likely to give rise to a claim within thirty (30) days or as soon as is reasonably practicable after the date of any circumstances, incident or occurrence. The **policyholder** and/or the **insured person** or any other person entitled to make a claim under the **policy** must at the expense of the **policyholder** and/or the **insured person** or any other person entitled to make a claim under the **policy** give **us** any certificates, information, evidence and other documentation as **we** will reasonably require.

Pre-approval in-patient and direct billing

We recommend all non-emergency **in-patient treatment** to be pre-approved by **us** prior to admission to the **hospital**.

The **policyholder** and/or the **insured person** can take advantage of direct billing facilities for **in-patient treatment** within **our** international directory of **hospitals** stated on the **Myglobe website**. The **insured person** should confirm with the **hospital** that it has received **our** written pre-approval before treatment. If it has not, **we** must be contacted immediately.

Where the **insured person** receives treatment for a **bodily injury**, **sickness** or pregnancy that is not covered under the terms of the **policy**, the **policyholder** and/or the **insured person** will be and remain liable for the costs of such treatment.

In the event that **we** pay for any treatment that is not covered by **our** written pre-approval confirmation of the treatment, then **we** are entitled and will recover any amount not covered from the **policyholder** and/or the **insured person**. When issuing confirmation of cover for any **in-patient treatment**, **we** will confirm some or all of the following:

(a) If the **insured person** is covered under the **policy**

(b) If the planned treatment is covered under the **policy**

(c) If the planned treatment is **medically necessary**

(d) If the planned treatment cost falls within the remaining benefit limit as stated in the **certificate of insurance**.

Assistance and co-operation

The **policyholder** and/or the **insured person** must co-operate with **us** and on **our** request, assist in making settlements in the conduct of any demand or legal proceedings and in enforcing any right of contribution or indemnity against any person or organisation who may be liable to the **policyholder** and/or the **insured person** as a result of an **accident**, **bodily injury** or damage with respect to which cover is afforded under the **policy**. In this regard, the **policyholder** and/or the **insured person** must attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The **policyholder** and/or the **insured person** must not, except at the **policyholders** and/or the **insured persons** own cost, make any payment, assume any obligation or incur any expense other than for first aid to others at the time of **accident**.

If the **policyholder** and/or the **insured person** fails to follow or comply with any instructions or a direction issued or provided by **us** and/or **our** assistance team then **we** may decline cover, reduce or decline to pay a claim to the extent permitted by law.

Breach of condition

If the **policyholder** and/or the **insured person** does not comply with or are in breach of any of the general or specific conditions contained in this **policy** (including a claims condition) **we** may decline cover, reduce or decline to pay a claim to the extent permitted by law.

Decisions about treatment

We do not decide whether the treatment an **insured person** receives is given on an in-patient, day-care or out-patient basis. This must be decided by the **insured persons** attending **doctor** and/or **specialist**.

We rely on and receive the advice of the treating **doctor** and/or **specialist** unless there are reasons which in **our** opinion, would suggest that treatment should be or have been provided alternatively. **We** recognise that there may be valid reasons for the choice of a particular treatment made by the attending **doctor** and/or **specialist** and **our** intention in forming a view and making a decision about the treatment is to determine if it is **medically necessary** (where appropriate) and necessary and reasonable. In the event of any differences in opinion between **us** and the attending **doctor** and/or **specialist**, **we** may seek an independent medical assessment.

Treatment outside network

If an **insured person** requires treatment outside of **our** network of **hospitals**, the **policyholder** and/or the **insured person** should attempt to arrange pre-approval from **us** ideally five (5) working days prior to commencement of the treatment for which **our** pre-approval is required. Although **we** will endeavour to provide the necessary confirmation to the **hospital** to allow for direct payment of any service, this will not be guaranteed. In these circumstances, the **policyholder** and/or the **insured person** will be required to make direct payment arrangements with the **hospital** and to then submit a claim to **us** for **our** review and determination in accordance with the **policy**.

Second opinion

We may at **our** discretion ask for a medical assessment and medical report to advise and inform **us** about the medical circumstances related to the **policyholders** and/or the **insured persons** claim or to medically examine the **insured person** in connection with the claim. **We** may seek a medical assessment where there is uncertainty as to the nature or extent of **bodily injury** and/or **sickness** and/or **our** liability under the **policy**. In the event of any differences in opinion between **us** and the attending **doctor** and/or **specialist**, **we** may seek an independent medical assessment.

Identifying yourself

If the **insured person** intends to receive treatment in any of **our hospitals** stated in the **Myglobe website**, the **insured person** must always be identified and confirmed by **us** as a person covered under the **policy** as a condition of cover before commencing treatment under the **policy**. Failure to comply with this condition may prejudice **us** and expose the **policyholder** and/or the **insured person** to additional costs or out of pocket expenses.

Reimbursement

If any claims are paid by **us** for services which are provided and covered under the **policy** but which are or have been provided to any persons who are not covered under the **policy**, the **policyholder** and/or the **insured person** will be liable to reimburse **us** in full for any such amount.

Conflict of interest

Any treatment or medical services provided under or in connection with the **policy** by a health professional, alternative practitioner or any other practitioner of any kind whatsoever whether or not qualified, licenced and/or appropriately registered to provide such service, or by a **doctor**, **specialist** or **dentist** must not be provided by:

i. the **policyholder**;
ii. the **insured person**;
iii. a **close relative** of an **insured person** or the **policyholder**; or
iv. an **employee** or director of the **policyholder**.

Waiting period, excess and co-payment

Waiting periods and/or **excess** and/or **co-payments** may apply to certain benefits under the **policy** which are stated in the **certificate of insurance**. The **waiting period** is the length of time an **insured person** will not be able to claim for benefits as stated in the **certificate of insurance**.

Claim discharge

The payment of any claim by **us** does not discharge the **policyholder** and/or the **insured persons** obligations to comply with or to fulfil the terms and conditions under this **policy**. **We** are not obliged to pay any ongoing or future costs of continuing, or similar treatment in respect of a claim made or covered under this **policy**, even if **we** have previously paid for the same type of or similar treatment unless it complies with and continues to satisfy all of the relevant terms, conditions and exclusions under the **policy**.

General exclusions applicable to all Sections of the policy

The general exclusions in this Section apply to all sections of and benefits under the **policy** and all covers unless the **certificate of insurance** and any of the **policy** documents expressly specifies that an exclusion does not to apply.

We will not provide cover and **we** will not be liable to pay any claim or provide any benefit under this **policy** to the extent that it would expose **us** to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

We will not cover or pay any benefits arising out of any of the following:

1. costs incurred outside of the **area of cover** as stated in the **certificate of insurance** unless otherwise agreed to by **us**.
2. claim by any person covered under this **policy** who has attained the age of eighty (80) years in which case it will not prejudice any entitlement to claim benefits which have arisen or occurred on or before any person covered under this **policy** has attained the age of eighty (80) years.
3. **pre-existing condition**, except where approved by **us**.
4. treatment directly related to surrogacy whether the **insured person** is acting as surrogate or are the intended parent.
5. foetal surgery meaning any treatment given or undertaken on a foetus while in the womb.
6. treatment to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as aging, menopause or puberty and which is not due to any underlying disease, **sickness** or **bodily injury**.

7. treatment that begins, or for which the need had arisen, during the first ninety (90) days after birth for any newborn child conceived by artificial means or any form of **assisted conception/assisted pregnancy**.
8. costs incurred directly or indirectly as a result of any claim for treatment of a condition an **insured person** had prior to initially being covered under the **policy**. This exclusion will not apply if agreed to by **us**.
9. radioactivity or the use, existence or escape of any nuclear fuel, nuclear material or nuclear waste.
10. where a benefit is payable under Medicare, private health insurance policy, medical or hospital benefit fund, or reciprocal health agreement.
11. where payment of the benefit under this **policy** would result in **us** contravening a law of any country.
12. where payment of the benefit under this **policy** would result in **us** contravening a provision of the Health Insurance Act 1973 (Cth), National Health Act 1953 (Cth), Private Health Insurance Act 2007 (Cth) and Private Health Insurance (Health Insurance Business) Rules 2015 as amended or succeeded from time to time.
13. where payment of an benefit under this **policy** would result in **us** undertaking a “health insurance business” under the Private Health Insurance Act 2007 (Cth).
14. where payment of any benefit under this **policy** would result in this **policy** being a life policy for the purposes of the Life Insurance Act 1995 (Cth).
15. **us** contravening any workers compensation legislation and/or transport accident legislation in any country.
16. suicide or attempted suicide, or deliberately self-inflicted **bodily injury** or **sickness**.
17. being engaged in flying an aircraft or aerial device except as a passenger.
18. training or participating in a **professional sport** of any kind.
19. **war**, **civil war**, invasion, act of foreign enemy, rebellion, revolution, insurrection or military or usurped power.
20. illegal or criminal acts or omission committed by **policyholder** and/or the **insured person** or on behalf of any other person, whether or not they are acting with the **policyholders** and/or the **insured person’s** consent.
21. complication of infection with Human Immunodeficiency Virus (HIV) or any variance including Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC) except as provided for under Section One (1) Hospital in-patient benefits.
22. being under the influence of intoxicating liquor including having a blood alcohol content over the prescribed legal limit while driving, or being under the influence of any drug unless it was prescribed by a **doctor** or **specialist** and taken in accordance with a **doctor** or **specialist’s** advice.
23. travelling against the advice of a **doctor** or **specialist**.
24. claim for or related to any kind of bariatric surgery regardless of the reason the surgery is required including but not limited to the fitting of a gastric band or creation of a gastric sleeve.

25. claim for the removal of fat or surplus tissue from any part of the body whether or not it is **medically necessary** or for psychological reasons (including but not limited to breast reduction).
26. claim for parenting or other teaching classes including but not limited to ante-natal classes.
27. claim for treatment of nicotine or smoking dependence including but not limited to nicotine replacement therapy or treatment which arises from or is in any way connected with misuse or over dosage or excessive use of alcohol, medicine or any other kind of substance.
28. claim for treatment to correct refractive defects of the eyes such as long-sightedness or short-sightedness or astigmatism and/or lasik/laser eye surgery.
29. claim for all types of learning disorders, educational difficulties, behavioural difficulties, physical development or psychological development difficulties including assessment or grading of such difficulties. This includes, but is not limited to dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity (ADHD) and speech or language difficulties.
30. claim as a consequence of any treatment that is not covered by or provided in accordance with the **policy**, including increased treatment costs.
31. claim for any costs for treatment related to and/or of **congenital defects**.
32. administration costs or reports of any kind (unless otherwise accepted by **us**) or any other charges of a non-medical nature.
33. claim for any costs incurred by the **policyholder** and/or the **insured person** in the USA which would ordinarily be claimable under the **policy** unless it is stated in the **certificate of insurance** that worldwide cover applies to the **insured person**.
34. base jumping, cliff diving, flying in an unlicensed aircraft, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hand gliding, paragliding or micro lighting, parachuting, potholing, skiing off piste or any other winter sports activities carried out off piste.
35. costs from health hydros, spas, nature cure clinics, fitness centres or any similar place, even if it is registered as a **hospital**.
36. costs for nutritional supplements including but not limited to special infant formula and cosmetic products even if medically recommended or prescribed or acknowledged as having therapeutic effects.
37. claim for cryopreservation, or harvesting or storage of stem cells as a preventive measure.
38. costs for standard toiletries including but not limited to, shampoos, soaps, toothpastes, mouthwash, lotions, moisturiser, cleansers, shower gels, contraceptives, proprietary headache and cold cures, with or without prescriptions.
39. costs for telephone calls.
40. sleep disorders including, but not limited to, snoring, insomnia, obstructive sleep apnoea, or sleep study tests.
41. costs for investigations or the treatment of thinning hair or hair loss.

42. claim as a result of any complications arising out of any **alternative treatment** unless at the absolute instructions of the treating **doctor** and/or **specialist**.
43. use of any drug which has not been established as being effective or which is experimental or within clinical trials. This means it must be licenced by the European Medicines Agency if a person covered under the **policy** is receiving treatment in Europe, or the US Food and Drug Administration (FDA) if the person covered under the **policy** is receiving treatment anywhere else in the world, and be used within the terms of that licence. However **we** will pay if, before the treatment begins, it is established that the treatment is recognised as appropriate by an authoritative medical body and **we** have agreed on the associated costs in writing with the **doctor** and/or **specialist**.
44. treatment which has not been established as being effective or which is experimental. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies.
45. treatment which is required directly or indirectly as a result of cosmetic, elective or plastic surgery, or reconstructive surgery where the reconstructive surgery was not covered under the **policy**.
46. infertility, sterilisation or **assisted conception/assisted pregnancy**.
47. pregnancy or childbirth(delivery), caesarean section and any complications related to it unless this is specially included in the **insured persons** plan stated in the **certificate of insurance**.

For the avoidance of doubt, the above exclusions extend to any tests, investigations, treatment, items, conditions, activities and any related consequential expenses connected with those exclusions.

Claims procedures

Making a claim

All claims must be submitted to **us** with a claim form which can be obtained at www.nib.com.au/expathealth or by calling the contact centre on 1800 941 012 or +61 2 4047 0965 (if outside Australia). Alternatively claims can be submitted to **us** through the online claims portal at www.nib.com.au/expathealth/claims

The **policyholder** and/or the **insured person** and the treating **doctor** and/or **specialist** (where appropriate) must sign the claim form and send it back to **us** as quickly as possible, giving **us** all the information **we** request.

A fully completed claim form with original receipted invoices (where possible) will ensure that the claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of the claim and in some cases may lead to the claim form being returned to the **policyholder** and/or the **insured person** for completion.

It may be necessary for **us** to obtain additional medical information from the treating **doctor** and/or **specialist**. In such cases **we** may ask you to provide a claim form which includes medical information that has to be

completed by the treating **doctor** and/or **specialist**. If the **doctor** and/or **specialist** does not respond quickly to such a request payment of the claim may be delayed.

For treatment which requires or where **our** pre-approval is required, such approval must be received from **us** in writing prior to treatment commencing. **We** will provide the **policyholder** and/or the **insured person** a claim number which must be stated in any subsequent claim.

Please note that, for reimbursement claims, **we** recommend all claims be submitted within thirty (30) days of the treatment being received.

Where to send claims

Any claims, together with the completed claim form and original receipted invoices (where possible) should be mailed or emailed to:

nib Expatriate Health Insurance Claims
AXA PPP International
Phillips House
Crescent Road
Tunbridge Wells
Kent TN1 2PL
United Kingdom
nibexpatclaims@nib.com.au
1800 941 012 or +61 2 4047 0965 (if outside Australia)
24 hours,7 day a week.

Alternatively, claims can be submitted to **us** through the online claims portal at www.nib.com.au/expathealth/claims

General definitions

accident means a single physical event that occurs during the **period of insurance** and which:

(a) is unexpected, unintended, sudden, external and visible; and

(b) results solely, directly and independently of any other cause in an injury suffered by the **insured person** and that is both unforeseen and unsolicited by the **insured person**.

area of cover means one of the following as stated in the **certificate of insurance**:

(a) Worldwide; or

(b) Worldwide excluding USA.

application means the form which you are required to complete that will enable **us** to assess eligibility for cover under the **policy**.

AXA means **AXA** PPP International (a trading name of **AXA** PPP Healthcare Limited).

bodily injury means a **bodily injury** resulting solely from an **accident** and which occurs independently of any **sickness** or any other cause where:

(a) the **bodily injury** and **accident** both occur during the **period of insurance** and whilst you are an **insured person** under the **policy**.

(b) the ongoing treatment of a **bodily injury** occurs prior to an **insured persons period of insurance** where the treatment was covered and accepted as being covered under the **policy** of the preceding **recognised health provider** or by **us**.

certificate of insurance means the most current **certificate of insurance** issued by **us** to the **policyholder** which identifies the level of cover in respect of which an **insured person** is covered.

civil war means any of the following, whether declared or not, armed opposition, insurrection, revolution, armed rebellion, sedition, between two or more parties belonging to the same country where the opposing parties are of different ethnic, religious or idealistic groups.

close relative means the **insured persons spouse** or **partner**, fiancé, child, step-child, daughter-in-law, son-in-law, grandchild, parent step-parent, parent-in-law, grandparent, brother, brother-in-law, half-brother, sister, sister-in-law, half-sister, aunt, uncle, niece or nephew.

congenital defect means a birth defect and anomaly that is deleterious, which can be either physical, mental or biochemical whether or not it manifested, diagnosed or known about at birth but not a **newborn child congenital defect** as defined under Specific definitions applying to Section 5.

country of assignment means the country where the **insured person** is residing temporarily on a foreign business assignment for or in connection with the business of the **policyholder** or the country the **policyholder** specifies in the **certificate of insurance** and in which the relevant authorities (such as tax authorities) consider the **insured person** to be a resident of during the **period of insurance**.

country of residence means the country in which the **insured person** is naturalised, a citizen or permanent resident (i.e. holder of a multiple entry visa or permit) which gives the **insured person** resident health care rights in such country.

co-payment means a share of an expense that the **policyholder** and/or the **insured person** is required to pay after any **excess** that may apply to a claim under the **policy**. For these purposes, the **policyholders** and/or **insured persons** share of an expense is the amount which **we** do not or are not liable to pay under the **policy** and will be identified by **us** as a difference in the percentage of loss applicable to a benefit under the **policy** as stated in the **certificate of insurance**.

dependent child(ren) means the **insured persons** unmarried child who is under the age of:

(a) 19 years and living and residing with the **insured person**; or

(b) 25 years and is a full time student at an accredited institute of higher learning in the **country of assignment**, and who is primarily dependent on the **insured person** for maintenance and support.

doctor means a doctor or **specialist** who is registered or licenced to practice western medicine under the laws of the country in which they practice.

employee means any person in the **policyholder's** service including directors (executive and non-executive), board members and includes consultants, contractors, sub-contractors and/or self-employed persons undertaking work on the **policyholders** behalf.

excess means the amount the **policyholder** and/or the **insured person** must pay or **we** will not pay in relation to a claim in any one (1) **period of insurance** and which the **policyholder** and/or the **insured person** is required to pay, in respect to:

(a) an event **excess**, **we** will not pay this amount of each and every loss arising from the same event; and

(b) an annual aggregate **excess**, **we** will not pay this amount for the total of all losses in a **period of insurance** per single, couple or family cover.

The amount of an **excess** is stated in the **certificate of insurance** as a monetary amount.

home leave means a period not exceeding sixty (60) days during which the **insured person** temporarily returns to the **country of residence**. **Home leave** is effective from the date of an **insured persons** arrival in the **country of residence** and ends upon the **insured persons** departure from the **country of residence** to the **country of assignment**.

hospital means an institution (public or private) that is registered as a **hospital** for maternity, diagnosing, care and treatment of injured or sick persons and which has the following characteristics:

(a) has arranged diagnostic and surgical facilities, either on the premises or in facilities available to the **hospital** on a pre-arranged basis;

(b) provides twenty four (24) hours a day nursing services by registered nurses;

(c) is under the supervision of a **doctor**, and

(d) is not primarily a clinic, a place for custodial care, a place for the treatment of alcoholics or drugs addicts; or a nursing rest or convalescent home or home for the aged or similar establishment.

insured person means any person nominated by the **policyholder** for cover under the **policy** or the **policyholder** (as the case may be) and whose name appears on the **certificate of insurance** which may include an **employee**, **spouse or partner** and/or **dependent child**.

The **insured person** is not a contracting insured under the **policy** with **us** unless the **insured person** is also the **policyholder** stated in the **certificate of insurance**.

medically necessary means treatment or services provided to an **insured person** in a manner exercising prudent clinical judgment, for the purpose of evaluating, diagnosing or treating a condition, and that is:

(a) in accordance with the generally accepted standards of medical practice; and

(b) clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the **insured person**; and

(c) not more costly than an **alternative treatment** in the country of which it is undertaken at least as likely to produce equivalent therapeutic or diagnostic results.

myglobe website means a website **we** maintain that includes **hospitals** with which **we** have direct settlement arrangements accessible at www.nib.com.au/expathealth/claims

period of insurance means each term of cover under the **policy** which is stated in the **certificate of insurance** and is no longer than twelve (12) consecutive months of cover.

policy means this document as comprised of the Product Disclosure Statement, and Financial Services Guide, **certificate of insurance** and any other documents **we** may issue to the **policyholder** and which **we** inform the **policyholder** are part of the **policy** including but not limited to an endorsement and supplementary product disclosure statement.

policyholder means the organisation or person stated as the **policyholder** in the **certificate of insurance**.

pre-existing condition means any **bodily injury** or **sickness**, during the five (5) years preceding the **period of insurance**:

(a) in respect of which the **insured person** has been diagnosed; or

(b) for which the **insured person** has received medication, advice or treatment; or

(c) which the **policyholder** and/or the **insured person** should reasonably, in **our** opinion, have known about; or

(d) which existed or in respect of which the **insured person** has experienced symptoms even if the **insured person** has not consulted a **doctor** and/or **specialist** and includes all associated conditions.

For the purposes of the definition, **pre-existing condition** also includes a pregnancy.

premium means the **premium** as stated in the **certificate of insurance** that is payable in respect of the **policy** by the **policyholder**.

professional sport means any sport for which any fee or monetary rewards is paid as a result of any training or participation.

recognised health provider means any Australian general insurer who has a licence to underwrite expatriate insurance or other international health providers, including Australian registered private health insurers.

sickness/es means:

(a) any illness, disease or syndrome suffered by an **insured person**, or first manifesting itself during the **period of insurance**, but does not include **pre-existing conditions**; or.

(b) the ongoing treatment of an illness, disease or syndrome suffered by an **insured person** or first manifesting itself before the **period of insurance**, provided always that the treatment was covered and accepted as being covered under the **policy** of the preceding **recognised health provider** or by **us**.

specialist means a **doctor** registered and recognised for the specialists experience, qualifications and training in a particular branch of western medicine or surgery or in the treatment of a **bodily injury**, **sickness** or pregnancy.

spouse or partner means the **insured persons** husband or wife and includes a defacto and/or life partner of any gender with whom the **insured person** has continuously cohabited for a period of three (3) months or more and who is residing with the **insured person** in the **country of residence**.

very seriously ill means a medical condition certified by the treating **doctor** or **specialist** to be of such a serious nature or threat to an **insured persons** life as to warrant a notification to a **close relative** that the close relatives attendance is desirable.

waiting period means a stated period of time in which the **policyholder** and/or the **insured person** is unable to claim for a benefit under the **policy**. The **waiting period** if applicable, commences from the beginning of the **period of insurance** and is stated in the **certificate of insurance**.

war means a state of armed conflict, whether declared or not, between different nations, states, or armed groups using military force to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

we/**our**/**us** means certain underwriters at Lloyd’s (Insurer) and other service providers authorised to act on behalf of the insurer to issue and manage this **policy** including nib, Cerberus and **AXA**.

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